Non-Group Health Plan (NGHP) Section 111 Reporting Webinar

September 12, 2024

Presentation Overview

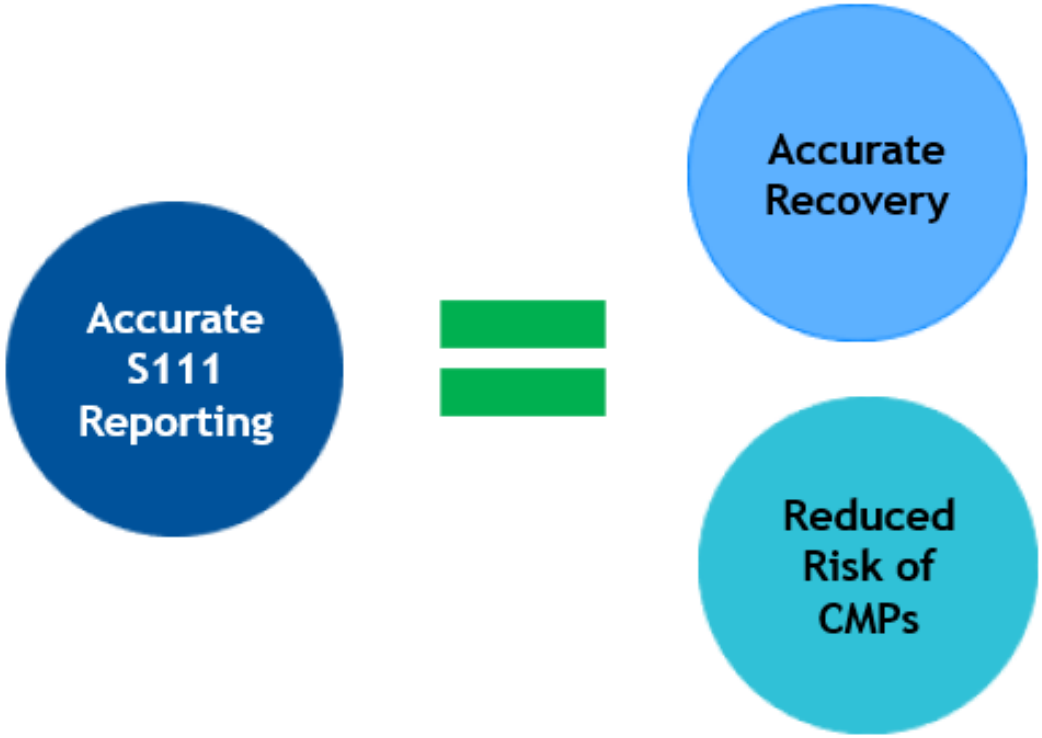
S111 Best Practices

Upcoming Changes

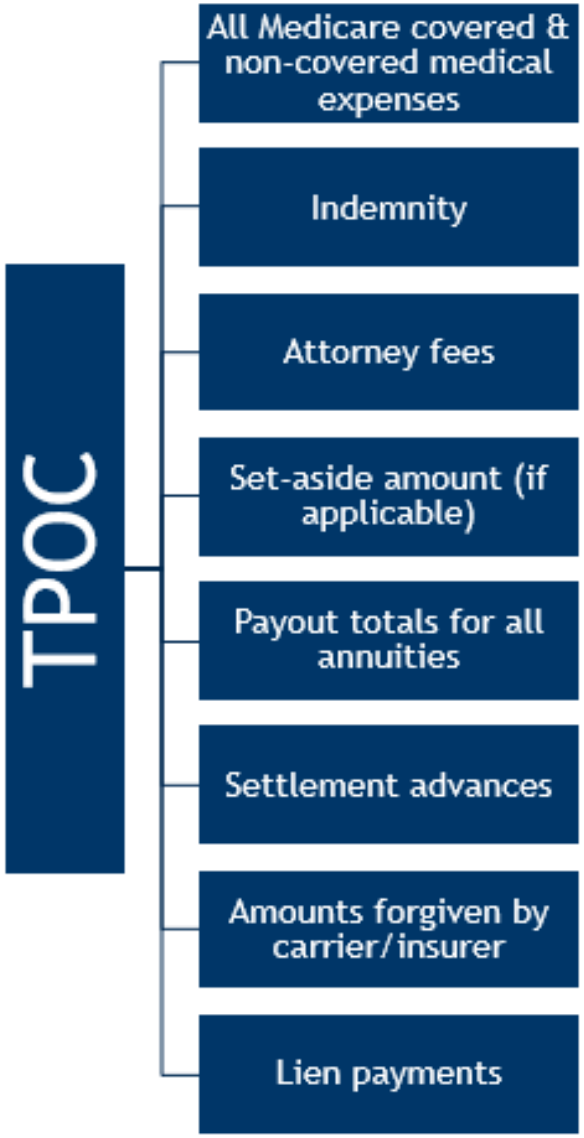
Additional Resources

Questions & Answers

Why Accurate Reporting Matters



Calculating TPOC

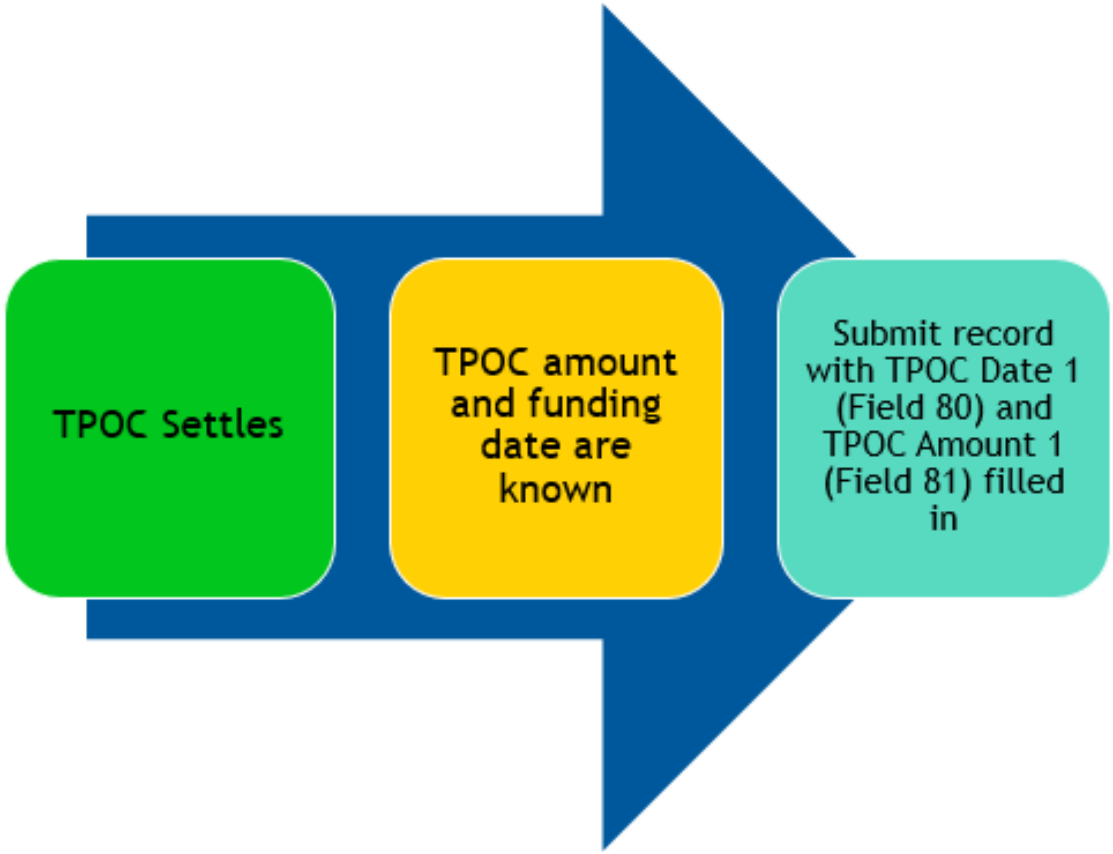


TPOC Reporting Reminders

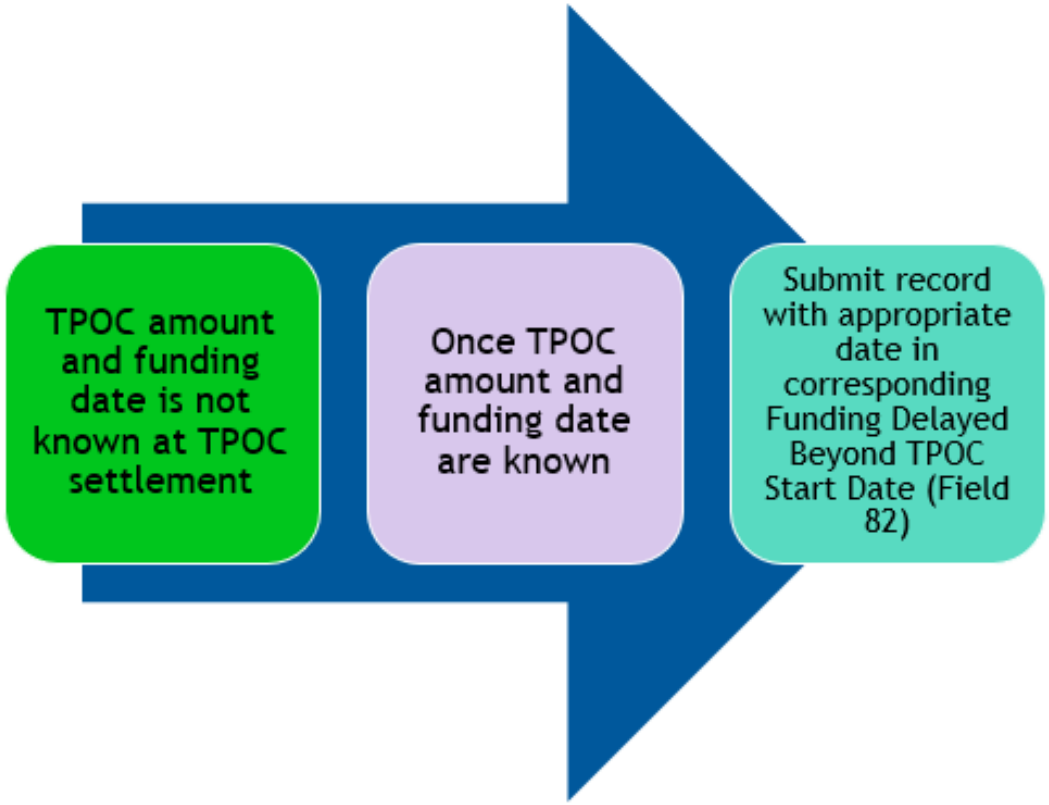
NGHP TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met:

- The alleged injured/harmed individual to or on whose behalf payment will be made has been identified.
- The TPOC amount (the amount of the settlement, judgement, award, or other payment) for that individual has been determined.
- The RRE knows when the TPOC will be funded or disbursed to the individual or their representative(s).

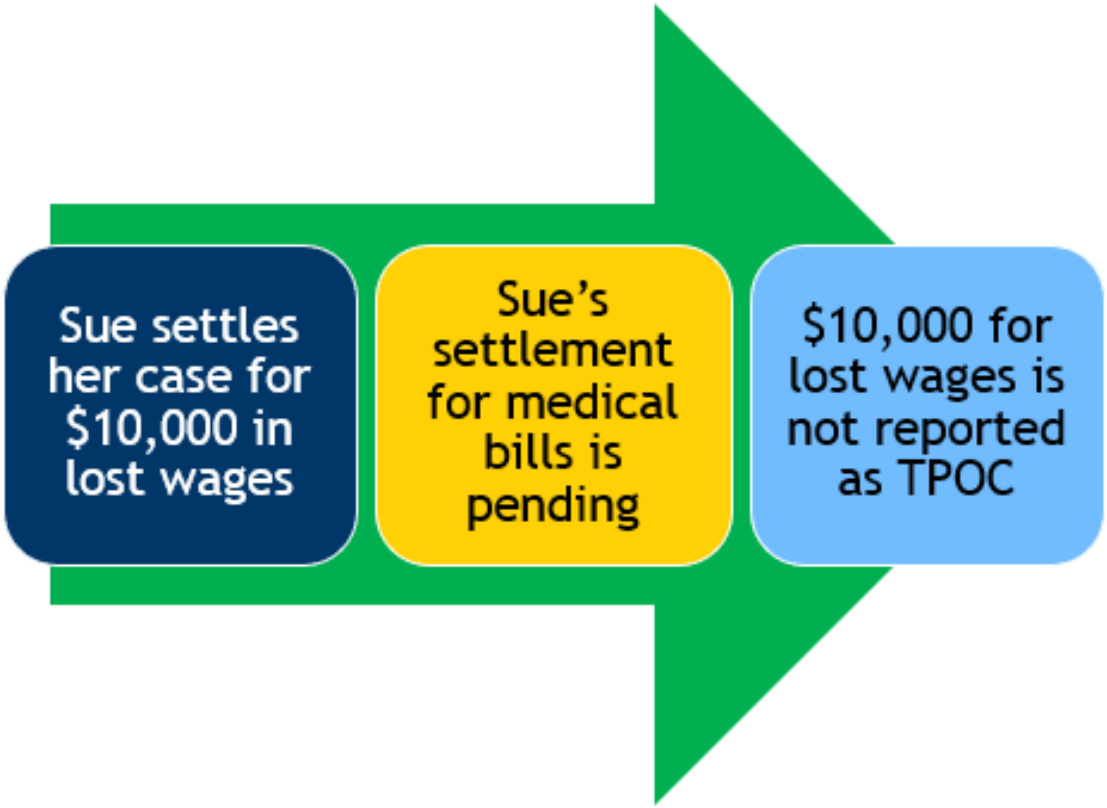
TPOC Reporting Example #1



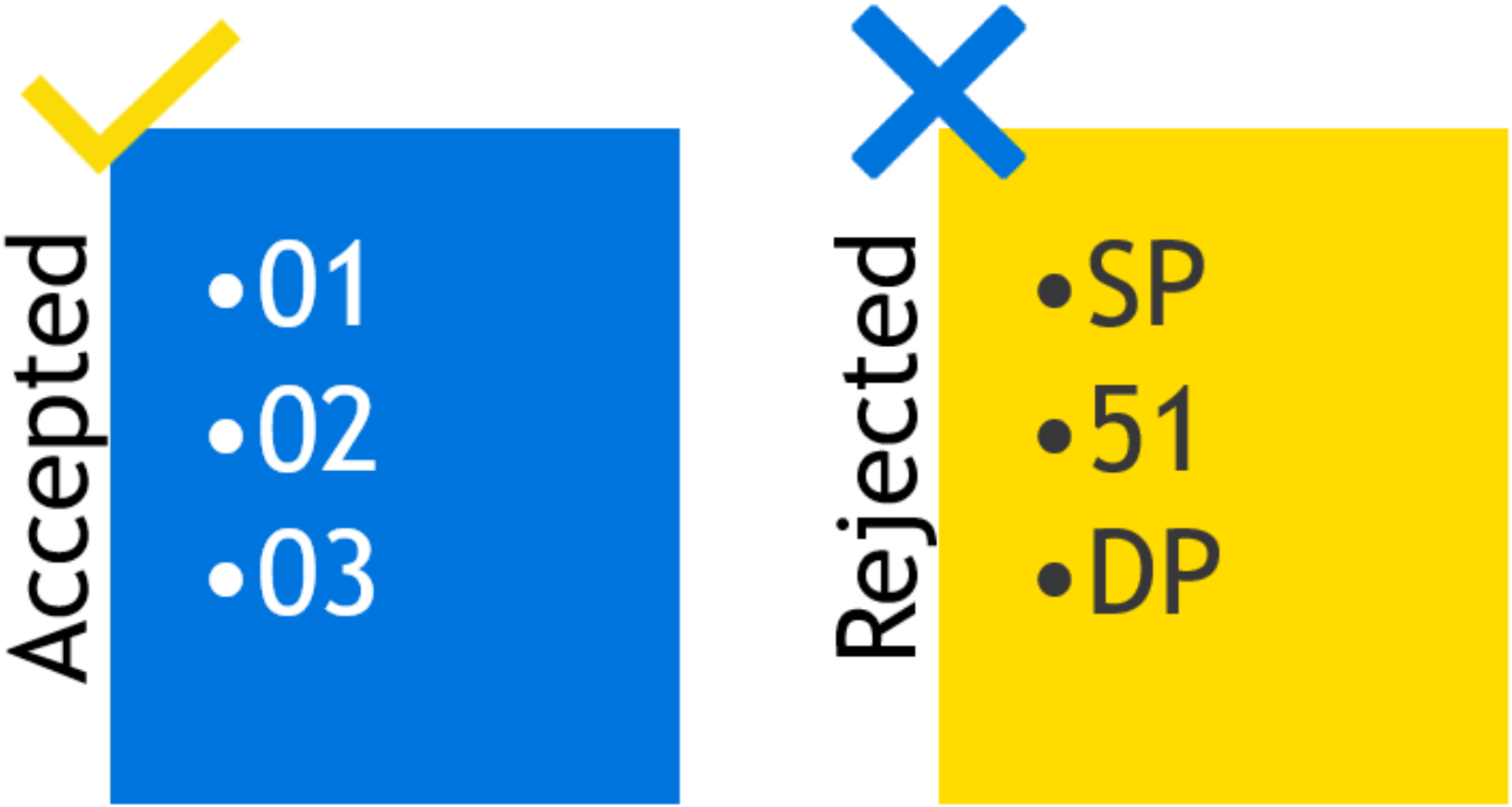
TPOC Reporting Example #2



Indemnity Settlement TPOC Example



Claim Response File Disposition Codes



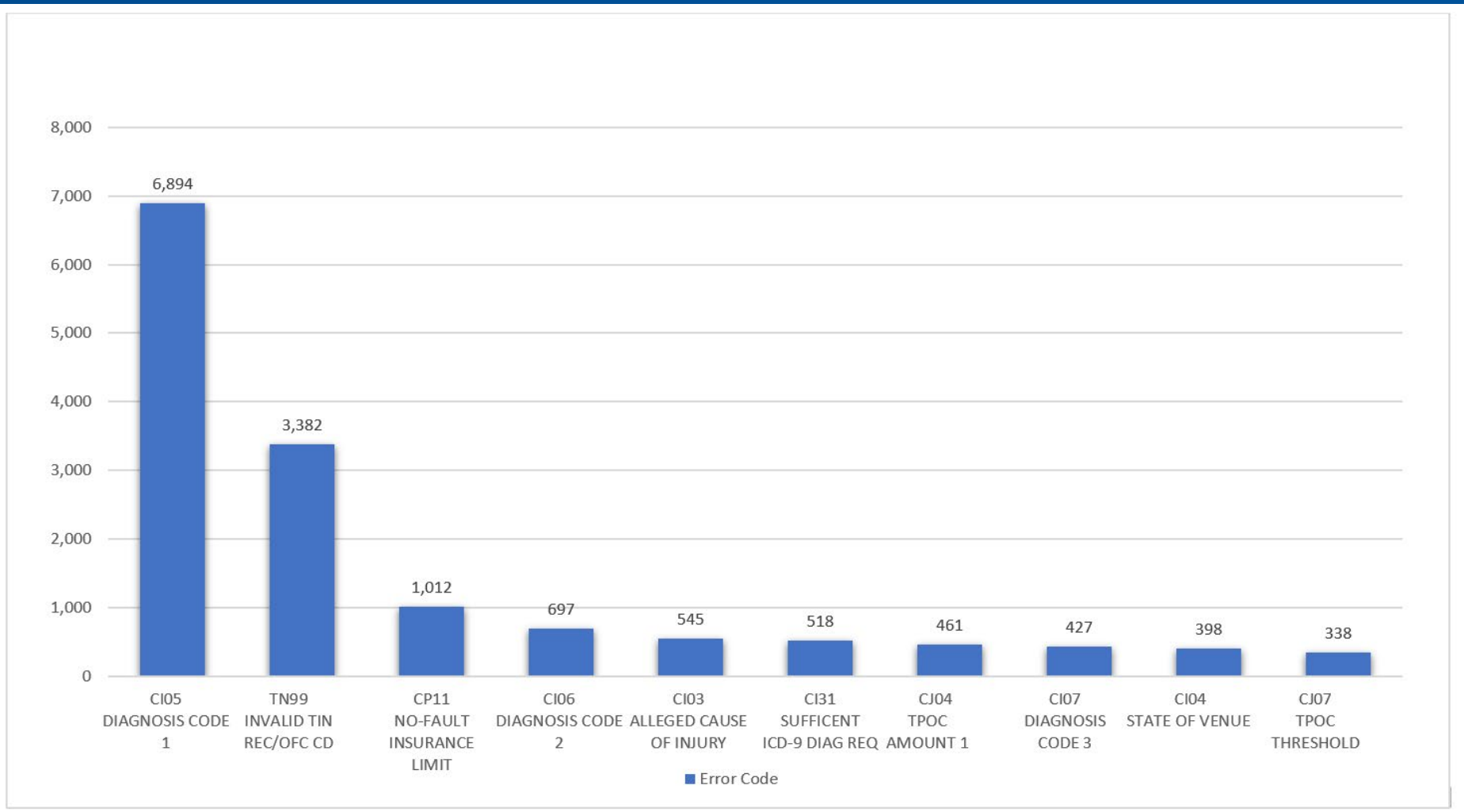
*Code DP and 51 can also be received on Query Response File

TIN Reference Response File Disposition Code

Rejected

- "TN"
- Only returned on the TIN Reference Response File

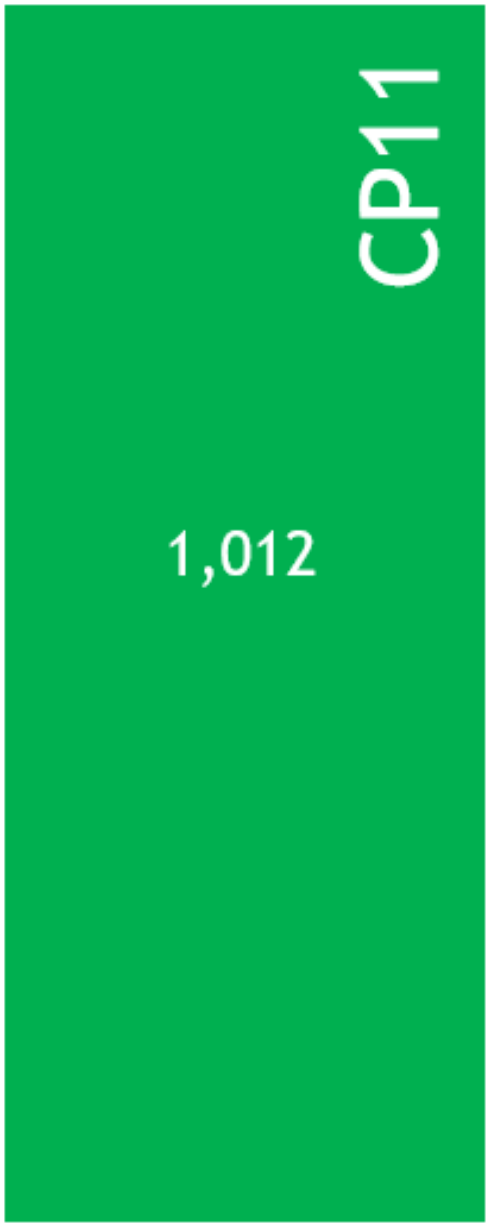
Top 10 Error Codes Jan 1-June 15, 2024



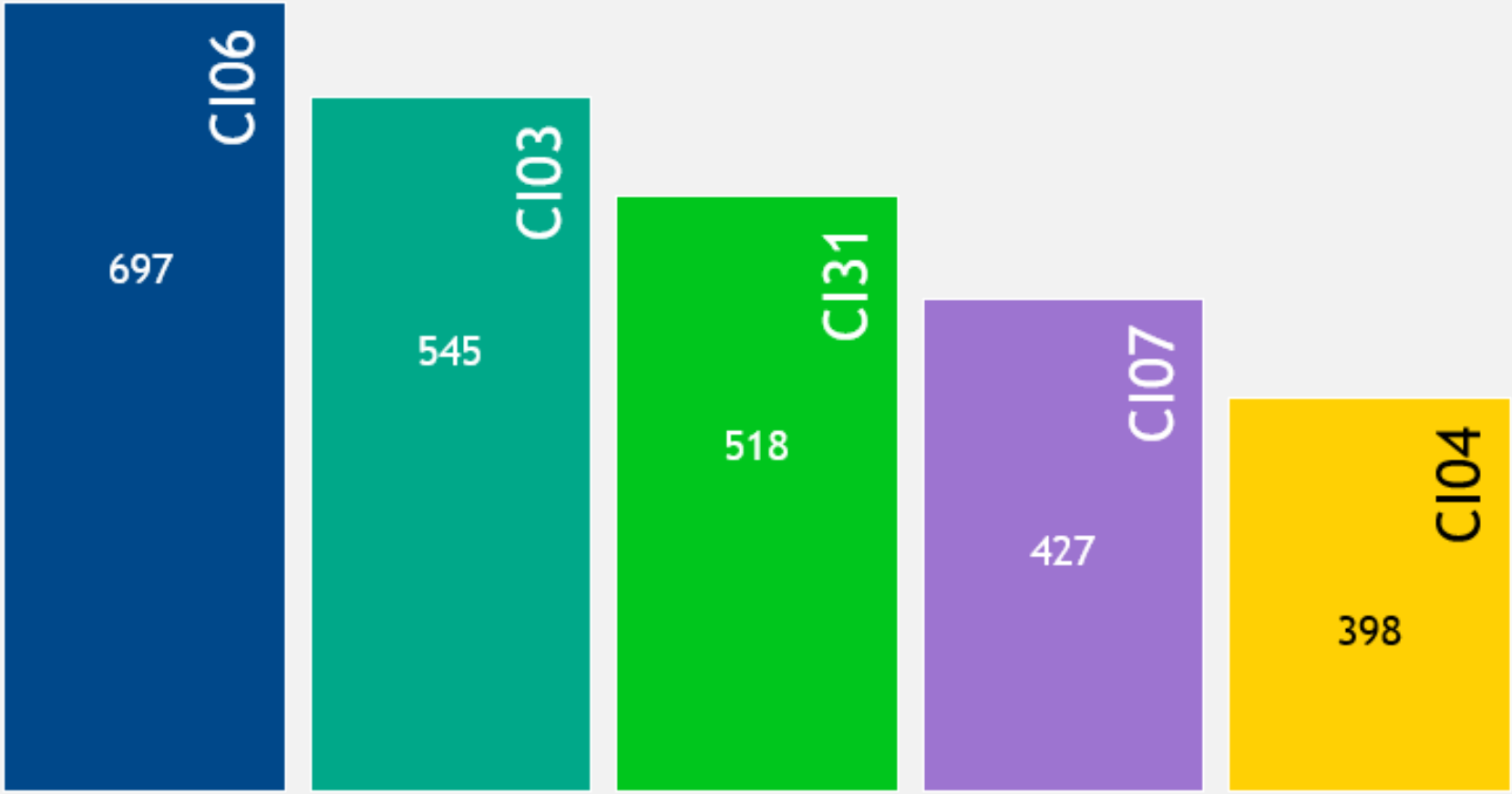
Claim Injury Errors

TIN File Errors

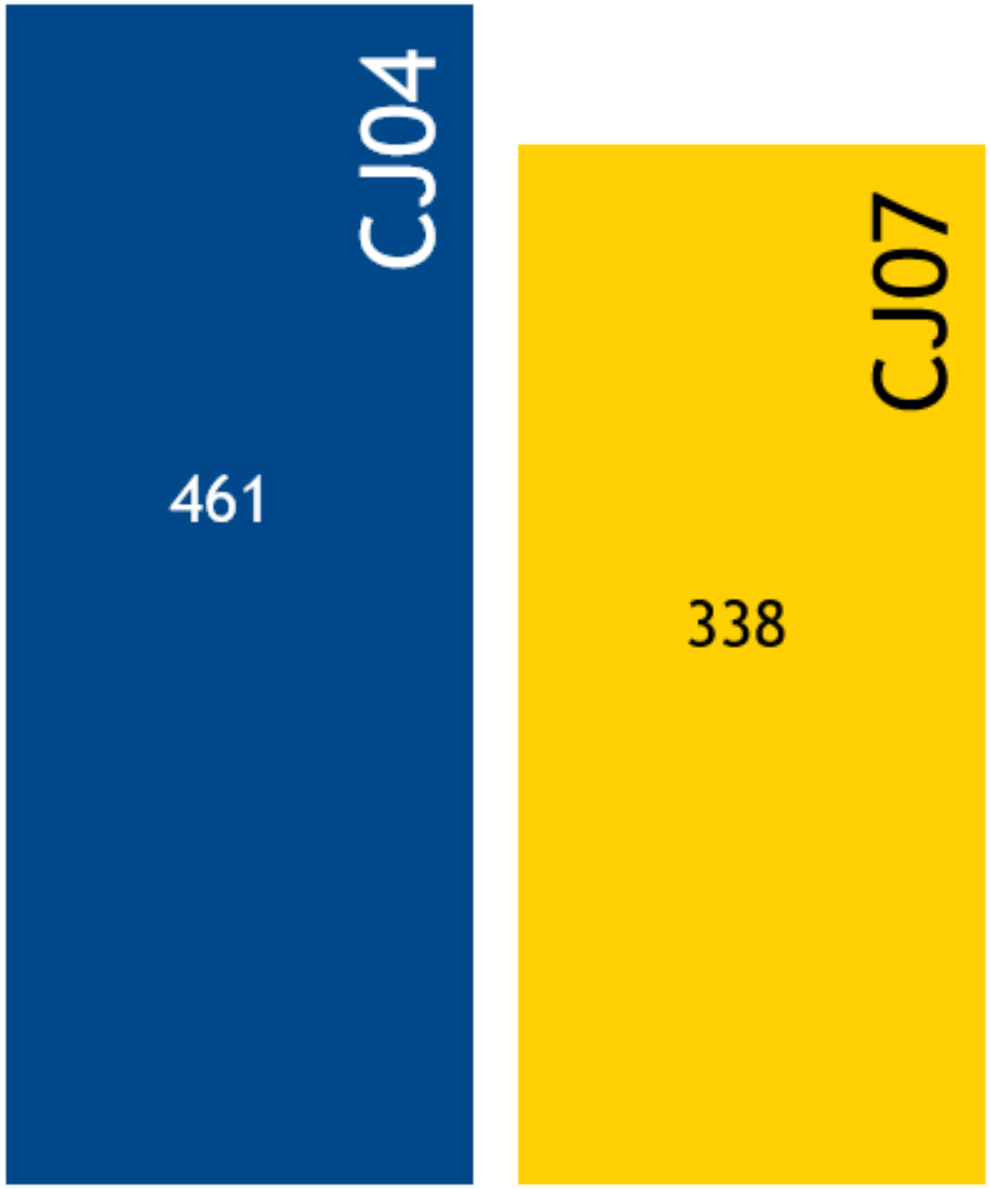
Claim Plan Information Errors



Claim Injury Error Codes



TPOC/ORM Related Errors



Resolving Errors

File

- Errors are returned in the Error Code fields on the response files
- Records will not be accepted

RRE

- Responsible for reviewing the response files for errors
- Must make corrections to the file and resubmit

Soft Edits

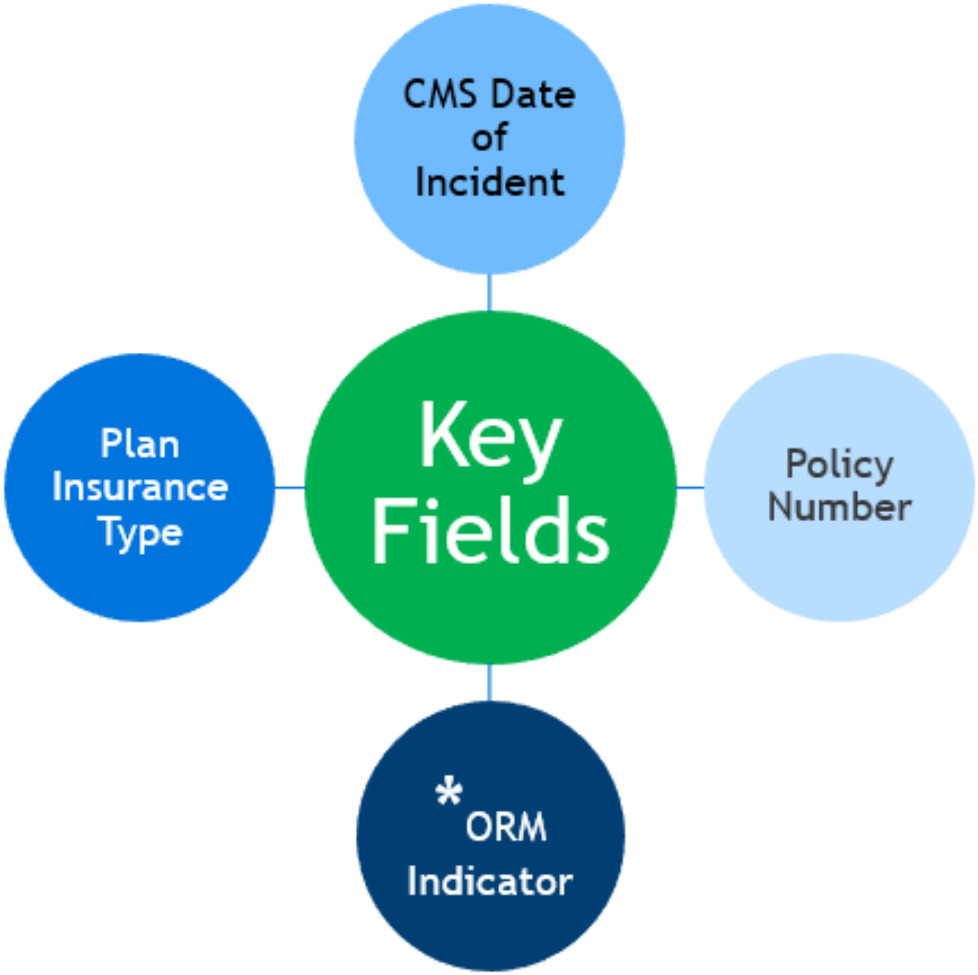
File

- Soft edits are returned in the Error Code fields on the Claim Response Files after all rejecting errors have been added to the response file
- Records will still be accepted

RRE

- Responsible for reviewing the response file for these edits
- Make corrections on their next quarterly file submission

Key Fields and the Delete/Add Process



Changing Reporting Agents

Scenario 1: RRE moves NEW business to a new Third-Party Administrator (TPA) and is leaving all existing claims with the current TPA.

- RRE will need to setup a new RRE ID for the new TPA to use for reporting new claim data
- Current TPA will use existing RRE ID for reporting of existing claims
- New TPA will use new RRE ID for reporting of NEW claims
- No Section 111 update is required for existing claims

Changing Reporting Agents Continued

Scenario 2: RRE moving NEW business and existing claims to a new TPA (takeover).

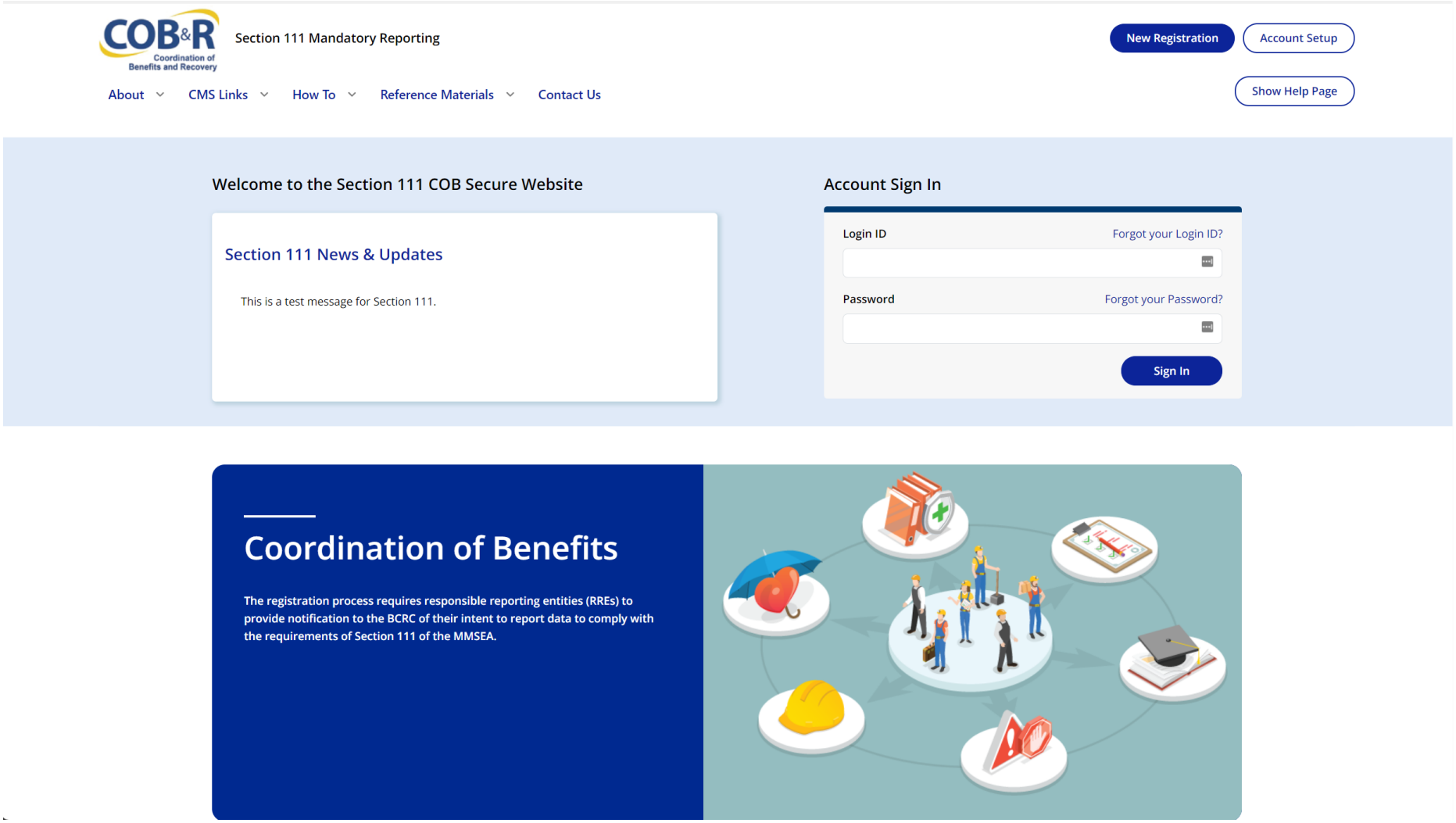
- RRE will transfer existing RRE ID to new TPA as part of the takeover; no new RRE ID is required
- Delete records will need to be submitted for the prior report and match on the key fields (CMS DOI, Plan Insurance Type, original Policy Number, and ORM Indicator)
- Add records will need to be submitted and include the NEW Policy Number

Changing Reporting Agents Example

ACME moved their business from ABC TPA to XYZ TPA on 01/01/2021.

- ABC TPA reported claim to Medicare via Section 111 with their Policy Number
- ACME transfers RRE ID to XYZ TPA and contacts EDI Rep to update account information
- XYZ TPA submits delete records for claims with the ABC TPA Policy Number
- XYZ TPA submits add records for claims with the XYZ TPA Policy Number

S111 Coordination of Benefits Secure Website (COBSW) Upgrade



Important Reminders: Workers' Compensation Medicare Set-Aside (WCMSA) Reporting Changes

- CMS will be expanding the existing S111 reporting process to capture information on all Workers' Compensation (WC) claims involving Medicare beneficiaries who receive a settlement (i.e., Total Payment Obligation to Claimant (TPOC)) that include a Medicare Set-Aside (MSA).
- Submission of the data should be done regardless of whether the WC arrangement was reported to CMS under the voluntary WCMSA process, a non-CMS approved MSA or Evidence Based MSA (EBMSA), or if Ongoing Responsibility for Medicals (ORM) is ongoing for some injuries associated to the claim but not others.
- Data should be submitted for all WC TPOCs, regardless of the TPOC value.
- This change will be prospective for TPOCs on or after the implementation date of April 4, 2025.

WCMSA Reporting Change: Additional Reminders

- The intent of this change is to obtain additional information about TPOCs. If a TPOC is reportable under existing requirements, it continues to be reportable. Guidance about what is reportable is not changing.
- Per current WC reporting thresholds, all WC Settlements of $750 or more must be reported.
- There is no change to the voluntary WCMSA submission process and parties should continue to send in settlement agreements to finalize those MSAs that have been voluntarily reported.

WCMSA Reporting Change: Special Situations

- Handling for Third party liability claims
- Definition and calculation for MSA period.
- Multi-party defendant settlements.
- Partially resolved TPOC claims with remaining ORM.

WCMSA Reporting Change: Testing

- Testing will be available using the current S111 file testing process.
- Your EDI Representative is your point of contact for testing.
- Test files must be transmitted to the BCRC using the same transmission method that was chosen for production files (HTTPS, SFTP, or Connect:Direct).
- Test Medicare beneficiary data may be downloaded from the Section 111 COB Secure Website for RREs to use in testing.
- Testing available beginning **October 7, 2024.**
- Full details on testing are available in Chapter IV of the NGHP User Guide.

Coming Soon

CMP Webinars Coming in October

E-mail CMP Questions To:

Sec111CMP@cms.hhs.gov

Additional Resources

The EDI Department is available for assistance at (646) 458-6740.

For additional S111 information:

- Section 111 NGHP User Guide
- Section 111 NGHP Training Materials
- Section 111 Mailbox : PL110-173SEC111-comments@cms.hhs.gov

WCMSA Questions should be submitted to: S111WCMSA@cms.hhs.gov

Questions & Answers

Slide 0: Non-Group Health Plan (NGHP) Section 111 Reporting Webinar

Slide 1: Presentation Overview

During this presentation we want to offer some Section 111 best practices, go over some important dates and reminders, and remind you of additional resources that are available. Lastly, we will open the call up for questions and answers.

Slide 2: Why Accurate Reporting Matters

We want to begin today by reminding everyone why accurate S111 reporting is so important.

The purpose of Section 111 reporting is to allow Centers for Medicare & Medicaid (CMS) to pay appropriately for Medicare-covered items and services furnished to Medicare beneficiaries. Section 111 NGHP reporting of applicable liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim information helps CMS determine when other insurance coverage is primary to Medicare, meaning that it should pay for the items and services first, before Medicare considers its payment responsibilities.

This essentially means that the more accurate your S111 reporting is, the more accurate the recovery process will be. And the upcoming implementation of Civil Money Penalties (CMPs) will mean that the accuracy and timeliness of your reporting will be more important than ever.

Let's look at some tips and reminders to help you have the most accurate reporting possible.

Slide 3: Calculating TPOC

Total Payment Obligation to Claimant (TPOC) and its calculation tends to be a topic we often get questions about.

The TPOC Amount refers to the dollar amount of a settlement, judgment, award, or other payment in addition to or apart from Ongoing Responsibility for Medicals (ORM). A TPOC generally reflects an amount intended to resolve or partially resolve a claim. It is the dollar amount of the total payment obligation to, or on behalf of, the injured party. Individual reimbursements paid for specific medical claims submitted to a Responsible Reporting Entity (RRE), paid due to the RRE's ORM for the claim, do not constitute separate TPOC amounts.

It is important to remember that the computation of the TPOC amount includes, but is not limited to:

- All Medicare covered and non-covered medical expenses related to the claim(s)
- Indemnity (lost wages, property damages, etc.) (We'll talk a little more about indemnity on the next slide)
- Attorney fees
- Set-aside amount (if applicable)
- Payout totals for all annuities rather than cost or present values
- Settlement advances
- Lien payments (including repayment of Medicare conditional payments)
- Amounts forgiven by the carrier/insurer

Slide 4: TPOC Reporting Reminders

Remember that NGHP TPOC settlements, judgments, awards, or other payments are reportable once the following criteria are met:

- The alleged injured/harmed individual to or on whose behalf payment will be made has been identified
- The TPOC amount (the amount of the settlement, judgement, award, or other payment) for that individual has been determined
- The RRE knows when the TPOC will be funded or disbursed to the individual or their representative(s)

Slide 5: TPOC Reporting Example 1

Let's talk through a common TPOC reporting example. Let's imagine that there is a settlement and the TPOC amount and the funding date are known at the time of settlement.

In this case, the RRE should submit a record with TPOC Date 1 (Field 80) and TPOC Amount 1 (Field 81) filled in.

Slide 6: TPOC Reporting Example 2

Let's talk through another reporting example. Let's imagine that there is a settlement involving an allegedly defective drug where a large settlement is to be disbursed among many claimants. The settlement provides a process for determining who will be paid and how much.

There will be payment to a particular individual, but the specific amount of the settlement, judgment, award, or other payment to that individual is not known as of the TPOC Date.

RREs are to submit the date of the settlement in the TPOC Date field (Field 80) and the amount of the settlement in the TPOC Amount field (Field 81).

In this example, the determination of the TPOC Amount, as well as the funding or disbursement of the TPOC, will be delayed after the TPOC Date. Once the TPOC Amount and the date when the TPOC will be funded or disbursed are determined, the RRE should submit the record with the appropriate date in the corresponding Funding Delayed Beyond TPOC Start Date field.

Slide 7: Indemnity Settlement TPOC Example

Another question we get often about the TPOCs is about indemnity. As we just mentioned, the TPOC computation definition does include indemnity. However, an indemnity-only settlement should not be reported.

We are often asked if, when a claim settlement releases medicals at a later date, after an indemnity-only settlement, should the computation of the TPOC releasing medicals include the prior "indemnity-only" settlement? Or is the TPOC computation specific only to the payment issued when medicals are released?

And the answer is that a TPOC includes all payments included in the settlement, including indemnity payments. However, if an indemnity-only settlement is made prior to the release of medicals, and it truly is for indemnity-only, then it is not reportable. If, in that case, the rest of the settlement occurs,

which does release medicals, then the original indemnity-only settlement is not added back in or otherwise aggregated.

An easy way to determine if an indemnity-only settlement must be reported is to question whether that settlement was released, or had the effect of releasing, medicals, even if through a general release.

As an example, if Sue settles her case for $10,000 in lost wages but her settlement for her medical bills is still pending, the $10,000 is indemnity only and should not be reported, either upon the indemnity settlement or included when reporting TPOC for medicals.

Slide 8: Claim Response File Disposition Codes

Let's talk for a moment about Disposition Codes and what they mean. Every Claim Input File Detail Record will receive a disposition code on the corresponding Claim Response File Detail Record. On the Claim Response File Detail Record, the Applied Disposition Code is Field 27.

Disposition Codes tell you essentially what was done with your record and what, if anything, you need to do in return. Disposition Codes “01”, “02”, and “03” all indicate that your record was accepted.

Disposition Codes “SP”, “51”, and “DP” indicate that a record was rejected, and action must be taken to correct the record.

Let’s break these codes down a bit more.

An “SP” Disposition Code indicates that the Record was not accepted by the Benefits Coordination & Recovery Center (BCRC) due to errors in the data reported. The Record was returned with at least one error code. The RRE will need to review and correct the errors and then resubmit on the next quarterly file submission.

Disposition Code “51” means that an individual was not identified as a Medicare Beneficiary. For claims with no ORM, the RRE does not need to be resubmitted the record if all information submitted was correct.

For claims with ORM the RRE must continue to check the injured party’s Medicare status and report when he or she becomes a Medicare beneficiary until the ongoing responsibility ends.

A Disposition Code of “DP” indicates that multiple Medicare beneficiary records were identified based upon the data the RRE submitted. The DP (duplicate) Disposition Code will be returned if the last five digits of the Social Security Number (SSN) submitted on the claim input files, when combined with matching criteria (first initial of the first name; the first six characters of the last name; date of birth; and gender), return multiple records.

If an RRE receives the “DP” code, they should verify that the SSN, name, gender, and date of birth were entered accurately and resubmit. Or enter the full nine-digit SSN (if available) and resubmit. If the system is still unable to locate a distinct match after resubmission, the RRE can contact the BCRC and provide the claim information to the customer service representative to file a self-report.

In rare cases an RRE may receive a Disposition Code of “50”, which means the Record is still being processed. If this code is received, the RRE must resubmit the Record on the next quarterly file submission.

Slide 9: Tax Identification Number (TIN) Reference Response File Disposition Code

We also want to talk about the "TN" Disposition Code. This code is only returned on TIN Reference Response File. It indicates that the TIN Record was returned with at least one TN edit. The RRE will need to review and correct the errors and then resubmit on the next quarterly file submission.

Slide 10: Top 10 Error Codes January 1 to June 15, 2024

Next, let's talk about what happens when you receive an error. We are always looking at trends when it comes to error codes. We hope that by pointing these out the BCRC will see fewer of them in the future and your files will process more smoothly.

Each error code begins with a two-letter prefix which helps you to quickly determine what the error code is related to. Let's look in more detail at the top error codes for the last six months.

Slide 11: Claim Injury Errors

Let's begin with the most common error code: CI05. CI codes reference claim injury information.

CI05 is the error for Invalid Diagnosis Code 1 (Field 18). This is a required field. The most common reason for this error is that an RRE leaves the field blank, as a required field it must be populated with a valid ICD-9 or ICD-10 diagnosis code. Another common reason for this error is that an RRE populates the field with an invalid code or an improperly formatted code.

Codes should be left justified with no leading spaces or decimal points. For example, the ICD code of 038.42 should be submitted as 03842.

Certain codes are not valid for No-Fault insurance types (Plan Insurance Type is "D" in field 51), because they are not related to the accident, and may result in inappropriately denied claims. ICD-9 codes cannot begin with the letter "E" or "V." And ICD-10 codes cannot begin with the letters "V," "W," "X," "Y," or "Z.". The full list of valid codes can be found on the ICD Code Lists page on CMS.gov.

Slide 12: TIN File Errors

TIN related error codes are also some of the most common. These codes are identified by a TN prefix.

The most common is TN99:Nno matching, valid TIN Reference File Detail Record was found for the TIN/Office Code combination on the Claim Input File Detail Record (Fields 52 & 53).

If a match is not found to a valid TIN record, the Claim Input File Detail Record will be rejected and returned on the Claim Response File with a TN99 error code, indicating that a valid TIN/Office Code record could not be found. This error will not provide information as to why the TIN record was rejected. RREs should refer to the errors identified and returned on their TIN Reference Response Files to determine what caused the matching TIN record to be rejected.

The RRE will then need to resubmit the corrected TIN Reference File records, and also resubmit the corresponding Claim Input File Detail Records that were rejected, either in their next file submission or as instructed by their Electronic Data Interchange (EDI) Representative.

Slide 13: Claim Plan Information Errors

Plan errors in the Claim Input file begin with the prefix CP. The most common recently has been CP11 for Invalid dollar amount of limit on no-fault insurance (Field 61).

The most common cause for this error is the RRE has filled the field with zeros for no-fault claim records. If Plan Insurance Type is D and there is no such dollar limit, the RRE should fill the field with all 9s, otherwise they should specify the actual amount.

The dollar amount should represent a combined total of Med-Pay and Personal Injury Protection (PIP). The RRE should specify dollars and cents with the implied decimal. There should be no formatting using the dollar sign, a comma, or decimal point. For example, a limit of $10,500.00 should be coded as 00001050000.

Again, this field may not be blank. It must contain a valid numeric amount, all zeroes or all 9s. If the Plan Insurance Type (Field 51) is D (No-Fault Insurance) and there is no such dollar limit, fill with all 9s. If Plan Insurance Type (Field 51) is E (Workers' Compensation) or L (Liability Insurance), the field can be filled with all zeroes.

Slide 14: Claim Injury Error Codes

Another group of error codes that the BCRC sees a lot of are the Claim Injury error codes, which are identified by the CI prefix. These codes are all related to the claim injury information in fields 17-36.

Let's look at some of the most common of these errors.

CI06 - Invalid Diagnosis Code 2 (Field 19). The most common reason for this error is that an RRE filled the field with spaces or an invalid code was submitted. The RRE can leave the ICD code 2 field blank if the injury only affects one body part. The ICD code 2 field is only required if more than one body part is affected.

CI03 - Invalid Alleged Cause of Injury, Incident, or Illness (Field 15). The most common cause for this error is that an RRE sends invalid ICD codes in the Alleged Cause field. The RRE should make sure if they are populating this field that they use a valid ICD-9 or ICD-10 code. Note that this is an optional field so the RRE can leave this field blank if they do not have a valid ICD code.

CI31 - Invalid ICD Indicator value (Field 17). This is a required field so must be populated. Valid values include "0" for ICD-10-CM diagnosis codes or "9" for ICD-9-CM diagnosis codes or Space for ICD-9-CM diagnosis codes.

Note that claims submitted with a CMS DOI on or after October 1, 2015 that contain an ICD indicator of "9" or space will be rejected with a CI31 error because an ICD-10 must be used.

CI07 - Invalid ICD Diagnosis Code 3 (Field 20). Again, as with the other ICD code-related errors the RRE needs to ensure that the ICD value is valid for Section 111 reporting. Valid codes are available on CMS.gov for reference. Also note that this field is only Required when three or more body parts are affected.

CI04 - Invalid State of Venue (Field 16). The reason for this code is that the RRE didn't populate the field with a valid US Postal state abbreviation such as 'NY' for New York or the field may have been left blank. This is a required field and cannot be blank.

Slide 15: TPOC/ORM Related Errors

Last let's look at the common CJ error codes, which indicate fields related to ORM or TPOC information.

CJ04 - Invalid Total Payment Obligation to the Claimant (TPOC) amount 1 (Field 81). This error occurs when an RRE enters non-numeric data or spaces, the field is not entered as all zeros when TPOC Date 1 (Field 80) is all zeros; or the field is all zeros when Field 80 has a non-zero value.

It should be noted that this field is not required for the initial report of a claim reflecting ongoing responsibility for medicals. If there is a TPOC amount/date reportable at the same time ORM termination is being reported, report the TPOC fields on the second (final) report for the ongoing responsibility for medicals. The RRE should submit all zeroes if there is no TPOC to report.

It is a required field for all other claim reports.

The CJ07 error code will only be returned if a liability, workers' compensation, or no-fault claim report is submitted where the ORM Indicator is set to "N" and the cumulative TPOC amount is zero. For 2024 the TPOC reporting threshold is $750 and RREs can reference the current and historical TPOC thresholds information in Section 6.4 of Chapter 4 of the NGHP user guide.

Slide 16: Resolving Errors

Now that we have looked at common error codes it is also important to understand the difference between errors that will cause a file to reject and soft edits which do not.

Hard errors cause the rejection of a file submission and for the records to not be accepted. Some errors result in rejection of TIN Reference File Detail Records and can also cause rejection of associated Claim Input File Detail Records. When an RRE receives errors on the response file, they must make the appropriate corrections and resubmit the files. These errors must be corrected by the RRE and the file resubmitted.

The errors we have been discussing in detail today, like CP11 for Invalid dollar amount of limit on no-fault insurance (Field 61) or CJ04 Invalid Total Payment Obligation to the Claimant (TPOC) amount 1 (Field 81), are all hard errors.

There is a full breakdown of all error codes, their meanings, and how to resolve them in Chapter 5 of the NGHP User Guide. An RRE can also always reach out to their EDI representative if they have additional questions about the errors they receive and how to resolve them.

While no errors is the ultimate goal, resolving any errors correctly and timely will be important to an RRE so that records are posted timely, which will help an RRE avoid CMPs.

Slide 17: Soft Edits

Some errors are considered soft edits, and incoming records are not rejected due to these errors. These soft edits are returned in the Error Code fields on the Claim Response Files after all the errors that would cause an error to be rejected have been added to the response file. Examples of soft errors are CC11 Claimant 1 Zip Code (Field 95) or CI02 Industry Date of Incident (Field 13).

While records with these soft edits will be accepted (having disposition codes of "01", "02", or "03"), RREs are still responsible for reviewing the response file for these edits and should make corrections on their next quarterly file submission.

Again, full details on all these codes and how to correct them can be found in Chapter 5 of the NGHP User Guide.

Slide 18: Key Fields & the Delete/Add Process

Next, let's talk about key fields. Medicare stores information on claims submitted previously using certain fields that identify the beneficiary, as well as the following key fields:

- CMS Date of Incident,
- Plan Insurance Type (Liability, No-Fault, Workers' Compensation),
- Policy Number, and
- ORM Indicator.

This information is used for beneficiary record matching purposes. It is important that the key fields stay up to date and are updated correctly.

To update key fields:

RREs submitting a Claim Input File should follow the "Delete-Add" process as outlined in Chapter 4 Section 6.6 of the NGHP User Guide.

For example, an insurance company took over claims from a previous insurance company and, as a result, the policy number changed. On the next Claim Input File, since updates cannot be submitted on previously reported claims using the original policy number, the RRE must first delete the previously reported record and then add a record with the new insurance carrier name and policy number.

Please note that the ORM Indicator field should only be updated using the Delete/Add process when ORM is submitted as Yes in error. In these instances, the RRE should delete the incorrect record and then submit an add transaction with the ORM as No along with the TPOC information.

Direct Data Entry (DDE) RREs should delete the claim in question and re-add it with the appropriate updates.

The Delete-Add process is only to be used when updating the key fields.

RREs should not be using the Delete-Add process if the beneficiary has a Medicare Beneficiary Identifier (MBI) or new MBI but was previously reported with a different identifier.

Lastly, to update any fields other than a key field, you should use the update process.

Slide 19: Changing Reporting Agents

Now we would like to talk about instances when changes to reporting agents need to be made by an RRE. Over the next few slides, we will talk through two scenarios and an example.

Scenario one is when an RRE is moving NEW business to a new Third-Party Administrator (TPA) and is leaving existing claims with their current TPA.

In this instance, the RRE will need to set up a new RRE ID for reporting of new claim data by the new TPA. The current TPA will use the existing RRE ID for reporting existing claims. The NEW TPA will use the new RRE ID for reports of new claims. No Section 111 update is required for existing claims.

Slide 20: Changing Reporting Agents cont.

Scenario two is when an RRE is moving NEW business and existing claims to a new TPA (in a takeover situation).

The RRE will transfer the existing RRE ID to the TPA, meaning no new RRE ID is required. Delete records will need to be submitted and match on the key fields as previously noted (CMS DOI, Plan Insurance Type, original Policy Number, and ORM indicator). Then Add records will be need to be submitted and include the new Policy Number.

Slide 21: Changing Reporting Agents Example

Let's look at scenario two, a takeover situation, in more detail with the following real-life example.

- ACME moved their business from ABC TPA to XYZ TPA on January 1, 2021.
- ABC TPA had previously reported to Medicare via Section 111 with their Policy Number.
- ACME transfers their existing RRE ID to XYZ TPA. XYZ TPA submits a delete record for claims with the ABC TPA Policy Number, ensuring to match on the other Key Fields.
- XYZ TPA then submits add records for claims with the XYZ TPA Policy Number.
- It is the RRE's responsibility to coordinate the transition of reporting from the former agent to the new agent and to notify your EDI representative of the change. Individuals from the new reporting agent should be given access to the RRE ID on the Section 111 Coordination of Benefit Secure Website (COBSW).

Slide 22: S111 Coordination of Benefits Secure Website (COBSW) Upgrade

We also just want to mention the recent upgrade to the Section 111 COB Secure Website. I am sure many of you have noticed the recent change.

The purpose of the upgrade was to enhance the end user experience across the application. While the functionality of the system didn't change, the layout and flow are new.

An updated user guide and help pages are available to assist you in navigating the changes. Should you experience any issues or have additional questions, please contact your EDI Representative.

Slide 23: Important Reminders: Workers' Compensation Medicare Set-Aside (WCMSA) Reporting Changes

We have talked throughout the presentation about how accurate reporting is so important and that is even more the case with some upcoming changes. So, we want to offer some important reminders and dates related to those changes.

The first being the upcoming Workers' Compensation Medicare Set-Aside (WCMSA) reporting changes. As you all know, the existing S111 reporting process is being expanded effective April 4, 2025, to capture information on all Workers' Compensation (WC) claims involving Medicare beneficiaries who receive a settlement (i.e., Total Payment Obligation to Claimant or TPOC), which includes a WCMSA.

Collection of the information will be done regardless of whether the WC arrangement was reported to CMS under the voluntary WCMSA process, a non-CMS approved Medicare Set-Aside (MSA) or

Evidence-Based MSA, or if Ongoing Responsibility for Medicals is ongoing for some injuries associated to the claim but not others.

Data should also be submitted for all WC TPOCs, regardless of the TPOC value.

It is important to note that this change will be prospective for TPOCs on or after the implementation date of April 4, 2025.

Full file layout changes and error code details are available in Chapter 5 of the NGHP User Guide.

Slide 24: WCMSA Reporting Change: Additional Reminders

The intention with this process is to obtain additional information about TPOCs. If a TPOC is reportable under existing requirements, it continues to be reportable. Guidance about what is reportable is not changing.

Per current WC reporting thresholds, all WC Settlements of $750 or more must be reported.

There is no change to the voluntary reporting process and parties should continue to send in settlement agreements to finalize those MSAs that have been voluntarily reported.

Slide 25: WCMSA Reporting Change: Special Situations

Third Party Claims – Where a settlement includes both a workers' compensation component along with other insurance types. Generally, these may be settled as a global settlement via the third party. Regardless of how final settlement expenses are addressed, CMS views the settlement as a workers' compensation settlement where the full value of the settlement and TPOC is reported by all parties.

MSA Period – The reported MSA period is expected to be the total period that the funds are expected to cover. In many cases, this is for the life of the claimant. Where statute provides for limitation to coverage periods, the period value may be less than expected lifetime.

Multi-party Defendant Settlements – Where there are multiple defendants involved with a single settlement, much like third-party claims, the full TPOC and MSA funds should be reported by each RRE involved, not simply that RRE's portion of the settlement.

Partially Resolved TPOC Claims with Remaining ORM – Where a portion of a claim is settled, but some items retain ORM with the insurer, normal TPOC reporting shall occur with edits to diagnoses made to reflect those injuries or body parts retaining ORM with the insurer.

Slide 26: WCMSA Reporting Change: Testing

We also know that many RREs will want to test these changes. And RREs will have that ability beginning this fall.

All RREs will have the option to test via the usual testing process. You must coordinate testing with your EDI representative.

RRE's must transmit test files to the BCRC using the same transmission method that was chosen for their production files (HTTPS, SFTP, or Connect:Direct). And test Medicare beneficiary data may be downloaded from the Section 111 COB Secure Website for RREs to use in testing. These files can be found under the Reference Materials section after Login.

Testing of the new fields will be made available for RREs beginning October 7, 2024. Records submitted on a test file with a TPC date on or after October 7, 2024, will be subject to the new edits in the test environment.

Additional information about the standard testing process is available in Section 9 of Chapter IV of the NGHP User Guide available on CMS.gov.

Slide 27: Coming Soon

The other major upcoming change is the implementation of Civil Money Penalties (CMPs)s. We just wanted to let you know that CMS will be hosting CMP webinars in October. So, stay tuned to CMS.gov for those announcements.

And in the meantime, if you have any CMP related questions you can submit them to the CMP dedicated mailbox at Sec111CMP@cms.hhs.gov.

Slide 28: Additional Resources

Before we end the presentation and start the Q&A section of the call, we want to remind you of other resources available to you.

The EDI Department is available to assist you with reporting questions and issues at 646-458-6740.

You can also find assistance on CMS.gov where the NGHP User Guide and NGHP Training materials are located. Lastly if you have S111 questions, you can submit them to Section 111 mailbox. As a reminder, please do not submit any Personally Identifiable Information (PII) or Protected Health Information (PHI) in your email.

Slide 29: Question & Answers